

FILED NOV 6 1942  
789

Registration District No. \_\_\_\_\_ Primary Registration District No. **115**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **University City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1230 Westover**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **Don't know** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mitchell Sorbia**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**  
6. (b) Name of husband or wife **Victoria Sarbie** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Don't know - about 62 yrs**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About	<b>62</b>			hr. _____ min.

9. Birthplace **Scotland** (City, town, or county) (State or foreign country)

10. Usual occupation **Clerk**

11. Industry or business **Washington University**

12. Name **Thomas Sarbie**  
13. Birthplace **Scotland** (City, town, or county) (State or foreign country)  
14. Maiden name **Geranne Burke**  
15. Birthplace **Scotland** (City, town, or county) (State or foreign country)

16. (a) Informant **Thomas Sarbie**  
(b) Address **1230 Westover Avenue**

17. (a) **Lake St. Charles** (Burial, cremation or removal) (b) Date thereof **10/10/42** (Month) (Day) (Year)  
(c) Place: burial or cremation **Lake Charles Cemetery**

18. (a) Signature of funeral director **Chas. J. ...**  
(b) Address **1519 So. Grand**

19. (a) **OCT - 8 1942** (Data received local health officer) (b) **C. D. ...** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town **1230 Westover Avenue** (If outside city or town limits, write "RURAL")  
(d) Street No. **University City, Mo.** (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct** day **6** year **1942** hour **2-30** minute **am**  
21. I hereby certify that I attended the deceased from **Aug 15, 1941** to **Oct 6, 1942** that I last saw him alive on **Oct 5, 1942** and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. Myocarditis**  
Due to **Hypertension Essential -**  
**retinal insufficiency &**  
**decompensation**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **Chas. J. ...** (M. D. or other) Address **2450 ...** Date signed **10/21/42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96  
3  
5  
0

Duration  
?  
?  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

NOV 1 1949

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Thomas J. Finner

Licensed Embalmer No. 1197

P. O. Address St. Louis, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.